

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009429

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 361

FILED FEB 23 1962

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Town & Country</u>		c. CITY OR TOWN <u>Town & Country</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>29 Hawthorne Estates</u>		d. STREET ADDRESS (If outside, give location) <u>29 Hawthorne Estates</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>R.</u> Last <u>SKOW</u>		4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/23/12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Park Commissioner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Louis County</u>	
11a. FATHER'S NAME <u>Peter Christ Skow</u>		11b. MOTHER'S MAIDEN NAME <u>Margaret Coulter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>[redacted]</u>	
17. INFORMANT <u>Mrs. Chas. R. Skow, 29 Hawthorne Estates</u>		18. NAME OF HUSBAND OR WIFE <u>Dorothy Skow</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour <u>7:05</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	
20g. STATE		21. I attended the deceased from <u>April 1958</u> to <u>time of death</u> and last saw him alive on <u>20 Jan 62</u>	
22a. SIGNATURE <u>Joseph G. Crust MD</u>		22b. ADDRESS <u>325 N. Kirkwood Rd, Kirkwood Mo</u>	
22c. DATE SIGNED <u>27 JAN 62</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>1/30/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Kirkwood, Mo.</u>		23e. STATE <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Louis H. Bopp, Inc., Kirkwood, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-29-62</u>	
26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>		27. DATE <u>27 JAN 62</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Francis J. Wyland Jr

Licensed Embalmer No. 4512

P. O. Address Kirkwood Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.